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MEDICAID MEMO

TO: Fee-for-service In-State and Out-of-State Hospitals, Including Freestanding Psychiatric Hospitals and State Mental Facilities, and Managed Care Organizations Participating in the Virginia Medical Assistance Program

FROM: Cynthia B. Jones, Director
Department of Medical Assistance Services (DMAS)

MEMO: Special

DATE: 6/13/2012

SUBJECT: Updates to the Medicaid Reimbursement Process for Hospital Acquired Conditions (HACs) – Effective July 1, 2012

The purpose of this memo is to notify providers that effective for dates of service on or after July 1, 2012, there will be several modifications to the current Hospital Acquired Condition (HAC) process. All inpatient hospitals, including state mental hospitals, freestanding Early and Periodic, Screening, Diagnosis and Treatment (EPSDT) psychiatric hospitals, and rehabilitation hospitals, will be required to submit present on admission (POA) indicators and be subject to the HAC criteria. This requirement is a change for psychiatric and rehabilitation hospitals. Certain conditions will be excluded from the HAC criteria for all inpatient hospital stays. These changes are to comply with federal regulations related to the Affordable Care Act.

Background on HACs/POAs

DMAS has been requiring the POA on all - UB claims since November 1, 2008. The Centers for Medicare and Medicaid (CMS) has a defined listing of ICD-9-CM diagnosis codes that are exempt from the requirement of a POA. DMAS has adopted these same diagnosis codes as exempt. For a complete listing of the diagnosis codes exempt from POA, please refer to the CMS website at: http://www.cdc.gov/nchs/data/icd9/icdguide10.pdf. This action was to assure compliance with CMS's requirements related to the Deficit Reduction Act (DRA) of 2005. Present on Admission is defined as the illness or condition present at the time the order for inpatient admission occurs – conditions that develop during an outpatient encounter, including emergency department, observation, or outpatient surgery, are considered as present on admission. The POA indicator is assigned to the principal and secondary ICD-9-CM diagnoses (as defined in Section II of the Official Guidelines for Coding and Reporting) and the External Cause of Injury Diagnosis codes.

The POA indicator is a required field on the claim and is to be indicated if:
• the diagnosis was known at the time of admission, or
• the diagnosis was clearly present, but not diagnosed, until after admission took place, or
• was a condition that developed during an outpatient encounter.

The 2009 Appropriations Act provided DMAS the authority to "eliminate reimbursement for HACs in a manner similar to the Medicare initiative implemented October 1, 2008." On January 1, 2010, DMAS implemented the CMS HAC payment provision for acute inpatient hospitals. DMAS utilizes the ICD-9-CM diagnosis and procedure codes defined by CMS as HACs. For a complete listing of the codes, please refer to the CMS website at: http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalAcqCond/Downloads/HACFactsheet.pdf

The diagnosis codes that are taken under consideration as HACs require a POA indicator to determine the point at which the condition occurred. Based on the information collected through the POA indicator, DMAS will determine whether a specific diagnosis should be included or excluded in the reimbursement calculation.

Acute inpatient hospitals are paid under the DRG methodology. If the primary, secondary, or external diagnosis code has a POA indicator of N or U, for a diagnosis code that is subject to the HAC policy, that code will be excluded from the DRG grouper. If the POA indicator is a "1" or blank, and the diagnosis code is exempt from POA reporting as determined by CMS, that diagnosis code will be included in the DRG grouper. For additional information on POA requirements refer to the December 2009 memo at https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/Home.

New HAC Exclusion

In accordance with federal regulations in response to the Affordable Care Act, DMAS will exempt from HAC consideration, cases where the onset of a deep vein thrombosis (DVT) and/or pulmonary embolism (PE) occurs in pediatric or obstetric patients following a total knee or hip replacement procedure.

For the purposes of this exemption, the following definitions apply:

Deep vein thrombosis/pulmonary embolism: Diagnosis codes 415.11, 415.19, 453.40-453.42
Total knee or hip replacement: Procedure codes 00.85-00.87, 81.51-81.52, 81.54
Pediatric: Age less than 18
Obstetric: Diagnosis codes 630-679 or V codes V22-24.2, V27-27.9, V28-V28.9

Expansion of HAC Participation

Effective July 1, 2012, DMAS will expand the HAC provision to inpatient psychiatric facilities, including freestanding EPSDT psychiatric hospitals and state mental hospitals; and inpatient rehabilitation hospitals. These facilities are paid on a per-diem methodology and HAC reimbursement adjustments will be made using a day reduction schedule. The day reduction schedule will include all ICD-9 codes that qualify as HACs and the average length of stay for each diagnosis. Claims with an ICD-9 code identified as an HAC and a POA code of 'N' or 'U' will have their total length of stay reduced by the average length of stay for the hospital acquired diagnosis code. For psychiatric claims with a 21-day limit, the total length of stay will be calculated based on the days prior to any HAC reduction. The day reduction schedule is based on the Thomson Reuters single average length of stay for each diagnosis code identified as an HAC. In the event, the day-reduction creates a partial day(s), DMAS will round to nearest full day reduction.

The following table provides examples of how the payment may be affected for each POA indicator.

CMS POA Indicator Reporting Options, Descriptions and Payments under the HAC Policy

POA Indicator	Description	Payment for acute care facility	Payment for inpatient rehab/psych facility
Y	Diagnosis was present at time of inpatient admission (Example: Diagnosis code = 599.0 with POA = Y)	Full payment will be made even if an HAC is present	Full payment will be made even if an HAC is present
N	Diagnosis was not present at time of inpatient admission (Example: Diagnosis code = 599.0 with POA = N)	The diagnosis code will not be sent to the DRG grouper when an HAC is present*	The day reduction will occur for the diagnosis code when an HAC is present
U	Documentation insufficient to determine if condition was present at time of inpatient admission (Example: Diagnosis code = 599.0 with POA = U)	The diagnosis code will not be sent to the DRG grouper when an HAC is present	The day reduction will occur for the diagnosis code when an HAC is present
W	Clinically undetermined. Provider unable to clinically determine whether the condition was present at the time of inpatient admission (Example: Diagnosis code = 599.0 with POA = U)	Full payment will be made even if an HAC is present	Full payment will be made even if an HAC is present
1	Exempt from POA reporting.	Exempt from POA reporting; full payment will be made	Exempt from POA reporting; full payment will be made

*Exclusion of diagnosis code from grouper may or may not impact final reimbursement.

Are You Ready for 300H Implementation?

Item #300H of the 2011 General Assembly Appropriation Act requires all providers to submit claims electronically via Electronic Data Interchange (EDI) or Direct Data Entry (DDE), and receive payments via Electronic Funds Transfer (EFT) for those services provided to Medicaid enrollees. If you are not already submitting claims electronically, please contact the EDI Helpdesk at 866-352-0766 for more information. If you do not receive your payment by EFT, please contact Provider Enrollment Services as soon as possible at 888-829-5373. The deadline for all providers to submit their claims electronically and receive payments by EFT is July 1, 2012.

VIRGINIA MEDICAID WEB PORTAL

DMAS offers a web-based Internet option to access information regarding Medicaid or FAMIS member eligibility, claims status, check status, service limits, service authorizations, and electronic copies of remittance advices. Providers must register through the Virginia Medicaid Web Portal in order to access this information. The Virginia Medicaid Web Portal can be accessed by going to: www.virginiamedicaid.dmas.virginia.gov. If you have any questions regarding the Virginia Medicaid Web Portal, please contact the Xerox State Healthcare Web Portal Support Helpdesk, toll free, at 1-866-352-0496 from 8:00 a.m. to 5:00 p.m. Monday through Friday, except holidays. The MediCall audio response system provides similar information and can be accessed by calling 1-800-884-9730 or 1-800-772-9996. Both options are available at no cost to the provider. Providers may also access

service authorization information including status via KePRO's Provider Portal, effective October 31, 2011 at http://dmas.kepro.org/.

ELIGIBILITY VENDORS

DMAS has contracts with the following eligibility verification vendors offering internet real-time, batch and/or integrated platforms. Eligibility details such as eligibility status, third party liability, and service limits for many service types and procedures are available. Contact information for each of the vendors is listed below.

Passport Health Communications, Inc. www.passporthealth.com sales@passporthealth.com Telephone: 1 (888) 661-5657	SIEMENS Medical Solutions – Health Services Foundation Enterprise Systems/HDX www.hdx.com Telephone: 1 (610) 219-2322	Emdeon www.emdeon.com Telephone: 1 (877) 363-3666

"HELPLINE"

The "HELPLINE" is available to answer questions Monday through Friday from 8:00 a.m. to 5:00 p.m., except on holidays. The "HELPLINE" numbers are:

1-804-786-6273	Richmond area and out-of-state long distance
1-800-552-8627	All other areas (in-state, toll-free long distance)

Please remember that the "HELPLINE" is for provider use only. Please have your Medicaid Provider Identification Number available when you call.